South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - ____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: ( ) -

The date of injury reported on Form 12A is: _____ (m/d/yyyy)

Check appropriate section(s). The employer's representative requests a hearing to:

I. ☐ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).
Compensation payments are current as of _____ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.
A Form 17 was offered and refused on _____ (m/d/yyyy).

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**
- ☐a. At any time pursuant to § 42-9-260(E).
- ☐b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is _____

III. ☐ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

_____

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).

IV. ☐ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V. ☐ **Determine amount of compensation for claims involving a fatality.** (Dependency investigation must be attached).
- ☐a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.
- ☐b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

A hearing requested pursuant to this section will be set on an expedited basis.

- A $ 25.00 filing fee and updated Form 18 must be included with an employer's request for a hearing.
- An employer requesting a hearing must include certification that the request has been served on all parties in compliance with R.67-211.

_____ _____ _____
Preparer's Signature Title Date

_____
Address

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or visit us online at www.wcc.sc.gov.